November 2016 – the challenges of embedding lessons learned

Immediately after a major incident or event, we often hear CEOs and politicians make a statement; something along the lines of "We are focussed on learning lessons to prevent this type of event happening in the future".

By definition the incident or event in question will be 'new' but the causes will not be new; we should be clear that the causes will be traceable back to 'old' lessons not being learned and / or implemented.

To learn lessons, a thorough and competent investigation must be commissioned. To deliver on the statement made above and deliver maximum value, organisations must be mature, open and committed.

A competent investigation must deliver the right outputs (ie establish the root causes, identify the right recommendations, manage the delivery of the recommendations and communicate the lessons learned). There are at least three fundamental requirements to enable these outputs:

1. Most importantly, remove any complacency, excuses or thoughts that the event 'could not happen here'
2. The basics of a thorough investigation process
3. The culture within the organisation to facilitate the investigation

Taking each of these in-turn:

1. Leaders must be 'mindful' of inherent weakness in the organisation. This equates to leaders asking the 'what could go wrong?' question and challenging constant 'good news'

2. Some of the fundamentals to ensure the investigation process will deliver high quality outputs include:

   - An assumption that the organisation has a health and safety management system (E.G. HSE HSG 65)
   - A procedure for reporting and investigating events
   - Competent investigation team (competent in the investigation process, familiar with the process / industry in which the incident occurred and possess the necessary 'people' skills)
   - Gathering all of the evidence – no assumptions or pre-conceptions
   - Analysing and integrating the evidence
   - Challenging the evidence to Identify any gaps
   - Testing the what, how and why
   - Generating conclusions and recommendations
   - Communicating recommendations and tracking closure

3. Leadership which enables a learning culture within the organisation:

- All hazards, near misses and events are reported by everyone
- Health and safety is a core value within the organisation (not a 'bolt-on')
- A 'Just culture' exists
- Conversations are held about health and safety
- Focus on establishing management and system failures rather than focussing on the errors of individuals
- Continual improvement to learn from peers and other good practices
- Commitment to embed lessons learned into business as usual
- Focus on the quality of action closure

Accidents and incidents often arouse powerful emotions. The ability to focus these emotions into positive forces to drive and deliver the necessary changes will assist an organisation to embed lessons learned.

Make sure you do everything you can to learn from incidents and events!

Read more of my blogs here.

The content of this article is intended to provide a general guide to the subject matter. Specialist advice should be sought about your specific circumstances.
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